

NAME:

DATE: / /

Account#:

## HISTORY OF ILLNESS / INJURY / PAIN

### LOCATION

Chief complaint and its location: \_\_\_\_\_

### TIMING & DURATION

How often do you experience this pain? \_\_\_\_\_ Constant \_\_\_\_\_ Frequent \_\_\_\_\_ Intermittent \_\_\_\_\_ Occasional

What caused the onset? \_\_\_\_\_

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

### SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None	1 = Minimal	2 = Very Mild	3 = Mild	4 = Mild to Moderate	5 = Moderate
6 = Moderate to Severe	7 = Mildly Severe, Restricts Some Activity			8 = Severe, Limits Most Activity	
9 = Very Severe			10 = Excruciating		

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

### ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ \_\_\_\_\_ Inflexibility \_\_\_\_\_ Stiffness \_\_\_\_\_ Spasms \_\_\_\_\_ Cramps

If this pain radiates or travels, please identify to where: \_\_\_\_\_

### QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp	_____ Stabbing	_____ Aching	_____ Pins & Needles	_____ Pounding	_____ Shooting
_____ Burning	_____ Dull	_____ Tingling/Numb	_____ Throbbing	_____ Crawling	_____ Stinging

### MODIFYING FACTORS

What aggravates the pain/symptom?

_____ Sneezing	_____ Lifting	_____ Exercising	_____ Looking up/down	_____ Walking
_____ Coughing	_____ Sitting	_____ Stooping	_____ Looking side/side	_____ Standing
_____ Stress	_____ Driving	_____ Getting out of bed	_____ Pushing	_____ Pulling
_____ Repetitive movement	_____ Carrying	_____ Straining at BM	_____ Climbing stairs	_____ Getting in/out of car

Other: \_\_\_\_\_

What relieves this pain/symptom?

_____ Resting	_____ Sleeping	_____ Lifting	_____ Exercising	_____ Looking up/down
_____ Shower	_____ Advil	_____ Stooping	_____ Looking side/side	_____ Mineral Ice
_____ Other: _____				

Over the past weeks/months this complaint is: \_\_\_\_\_ Improving \_\_\_\_\_ Getting worse \_\_\_\_\_ About the same

Have you seen anyone for this condition? \_\_\_\_\_ YES \_\_\_\_\_ NO WHOM? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Brian Sims, DC

NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ Account#: \_\_\_\_\_

## SECONDARY COMPLAINT & LOCATION

Location \_\_\_\_\_ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS & SYMPTOMS** Please check those that apply ➡ \_\_\_\_Inflexibility \_\_\_\_Stiffness \_\_\_\_Spasms \_\_\_\_Cramps

If the pain radiates or travels, please identify to where: \_\_\_\_\_

### QUALITY

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Sharp \_\_\_\_ Stabbing \_\_\_\_ Aching \_\_\_\_ Pins & Needles \_\_\_\_ Pounding \_\_\_\_ Shooting  
\_\_\_\_ Burning \_\_\_\_ Dull \_\_\_\_ Tingling/Numb \_\_\_\_ Throbbing \_\_\_\_ Crawling \_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_Improving \_\_\_\_Getting worse \_\_\_\_About the same

## THIRD COMPLAINT & LOCATION

Location \_\_\_\_\_ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS & SYMPTOMS** Please check those that apply ➡ \_\_\_\_Inflexibility \_\_\_\_Stiffness \_\_\_\_Spasms \_\_\_\_Cramps

If the pain radiates or travels, please identify to where: \_\_\_\_\_

### QUALITY

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Sharp \_\_\_\_ Stabbing \_\_\_\_ Aching \_\_\_\_ Pins & Needles \_\_\_\_ Pounding \_\_\_\_ Shooting  
\_\_\_\_ Burning \_\_\_\_ Dull \_\_\_\_ Tingling/Numb \_\_\_\_ Throbbing \_\_\_\_ Crawling \_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_Improving \_\_\_\_Getting worse \_\_\_\_About the same

## KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

\_\_\_\_\_  
\_\_\_\_\_

2. What do you enjoy doing most in your life?

\_\_\_\_\_  
\_\_\_\_\_

NOTES / COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

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Please place a checkmark by the condition that applies to you: P = Present • N = Not Present • PP = If it has ever been present in the past

P	N	PP		P	N	PP		P	N	PP		P	N	PP	
			Fatigue				Irritability				Joint Stiffness				Seizures
			Fever				Depression				Spinal Curvature				Dizziness
			Chills				Memory Loss				Back Pain				Tremors
			Night Sweats				Headache				Hot Joints				Loss of Sensation
			Fainting				Muscle Pain				Joint Swelling				Loss of Coordination
			Nervousness				Muscle Weakness				Stiff Neck				Paralysis
			Concentration Loss				Muscle Cramps				Lumps / Masses				Difficulty of Speech

P = Present • N = Not Present • PP = If it has ever been present in the past • Do the same for your family

Family History Key: F = Father • M = Mother • B = Brother • S = Sister • GF = Grandfather • GM = Grandmother

## Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? \_\_\_\_YES \_\_\_\_NO

Are you Pregnant? \_\_\_\_YES \_\_\_\_NO

Do you think you may be pregnant? \_\_\_\_YES \_\_\_\_NO

## FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

## REVIEW OF SYSTEMS

- |                                                 |                                        |                                                            |                                                    |
|-------------------------------------------------|----------------------------------------|------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Allergic / Immunologic | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Cardiovascular                    | <input type="checkbox"/> Hematological / Lymphatic |
| <input type="checkbox"/> Constitutional         | <input type="checkbox"/> Integumentary | <input type="checkbox"/> Ears / Nose / Mouth               | <input type="checkbox"/> Musculoskeletal           |
| <input type="checkbox"/> Endocrine              | <input type="checkbox"/> Neurological  | <input type="checkbox"/> Eyes                              | <input type="checkbox"/> Psychiatric               |
| <input type="checkbox"/> Gastrointestinal       | <input type="checkbox"/> Respiratory   | <input type="checkbox"/> All other system reviews negative |                                                    |

Notes / Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

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**PLEASE LIST PAST SURGERIES:**

1. \_\_\_\_\_ Year \_\_\_\_\_ 2. \_\_\_\_\_ Year \_\_\_\_\_  
3. \_\_\_\_\_ Year \_\_\_\_\_ 4. \_\_\_\_\_ Year \_\_\_\_\_  
5. \_\_\_\_\_ Year \_\_\_\_\_ 6. \_\_\_\_\_ Year \_\_\_\_\_

What other major injuries have you had?	Date	Have you ever taken:	YES	NO	YEAR
		Insulin			
		Cortisone			
		Thyroid Medicine			
		Male/Female Hormones			
What medications are you currently taking?	Date	Blood Pressure			
		Tranquilizers/Sedatives			
		Birth Control			

**Hospitalizations:**

\_\_\_\_\_

Marital Status: \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Single \_\_\_\_ Separated \_\_\_\_ Widowed

Number of Children: \_\_\_\_ Children's Name(s): \_\_\_\_\_

Frequency of Exercise: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately \_\_\_\_ Regularly

Intensity of Exercise: \_\_\_\_ Low Level \_\_\_\_ Medium Level \_\_\_\_ High Level \_\_\_\_ Competition Level

Sufficient Rest: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Hours of Sleep: \_\_\_\_ 6 \_\_\_\_ 8 \_\_\_\_ 10 \_\_\_\_ More than 10

Well balanced diet: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Do you smoke? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1 to 2 ppd \_\_\_\_ 2 to 3 ppd \_\_\_\_ 4 to 5 ppd \_\_\_\_ More than 5 packs/day

Do you drink caffeinated beverages? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1 to 2 \_\_\_\_ 2 to 3 \_\_\_\_ 4 to 5 \_\_\_\_ More than 5 drinks/day

Do you drink alcoholic beverages? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1 to 2 \_\_\_\_ 2 to 3 \_\_\_\_ 4 to 5 \_\_\_\_ More than 5 drinks/day

Have you ever used street drugs? \_\_\_\_ Yes \_\_\_\_ No

Hobbies: \_\_\_\_\_

\_\_\_\_\_

Patient history was obtained from: \_\_\_\_ Patient \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Son \_\_\_\_ Daughter

Notes / Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

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